CASE: Mr. Smith (not his real name), a 75 year-old vigorous man with no prior medical history, was found at home by his wife to be aphasic and hemiplegic. He was brought to the hospital and diagnosed with a large ischemic cerebrovascular event. Four days after admission, the patient had made no improvement and developed aspiration pneumonia. He was awake, in no distress, tracked with his eyes, and was able to grimace nonspecifically, but remained aphasic, had a dense right hemiparesis, and had little interaction with his family. He was no longer able to express his preferences. His wife requested that her husband be made comfort measures only. However, the following day, after discussion with her family, Mrs. Smith requested more aggressive care, stating that the children had difficulty coming to grips with the decision to institute comfort measures only. The palliative care team was consulted. Mr. Smith was an avid sportsman, coaching football and playing golf seven days a week. He was very proud of his children’s athletic accomplishments. His loving family included a wife of 53 years and three children. His wife described him as a very impatient man who had little tolerance for disability. As an example the wife told the story of a close friend and golfing partner who suffered a stroke that left him with residual hemiplegia. When the friend returned to the golf course, Mr. Smith would “turn around and leave” as he “couldn’t bear to see his friend in that condition.” Prior to the palliative care consultation, Mrs. Smith had again talked to her family and was now clear that the entire family agreed that comfort measures were Mr. Smith’s wishes. Mr. Smith had repeatedly told her that he didn’t want to live if he had any disability and would in fact be “angry” with her if she were not to follow these wishes. The patient had a living will stating that he did not want his life prolonged in case of an “irreversible” medical condition. The living will did not specifically address the issue of a large cerebrovascular event. The palliative care team was in agreement with the wife’s request for comfort measures. However, the primary team taking care of Mr. Smith had difficulty accepting these requests because 1) they had seen many similar patients make partial recovery; 2) Mr. Smith had no underlying terminal condition and 3) the team thought that withholding artificial nutrition would “actively” hasten Mr. Smith’s death. An ethics consultation was requested.

DISCUSSION: What are the ethical and legal standards for withholding care from patients who are not terminally ill?

1) *Is there a right to refuse care?* The right to refuse care receives its justification from our society’s value of autonomy. Competent patients have an ethical and legal right to refuse medical care. In addition, courts have upheld the right to use substituted judgment in cases when the patient is currently incompetent but the patient’s wishes are known.

2) *What types of medical care can be terminated or not instituted?* There is general agreement that any type of medical intervention, including artificial nutrition, can be terminated or not instituted.

3) *From what types of patients can care be withheld?* The ethical justification for the right to refuse care does not depend upon the individual being terminally ill. Competent patients who are not terminally ill may refuse any care.

4) *Who should act as the decision maker?* Courts have maintained that the patient’s choices should be determinative. Specifically, competent persons’ explicit statements, either in living wills or in conversations, indicating what type of care they would want if they became incompetent, should be determinative. Courts have also
permitted families to use their substituted judgment in withdrawing life-support from incompetent patients, who have not left any indication of their own preferences.

CONCLUSION: The ethics team agreed with the wife’s assessment and recommended comfort care only. Mr. Smith was discharged on the following day.

References: